STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

(916) 322-4990

April 10, 1980

To: All County Welfare Directors

Letter No. 80-13

MEDICAID INPATIENT HOSPITAL REIMBURSEMENT

Federal regulations (CFR 42-447.205) require that any change in the Statewide method or level of reimbursement for Medicaid services be publicly noticed at least 60 days before the proposed effective date of the change. A local agency in each county must also be identified where copies of the proposed changes are available for public review.

The county welfare offices in each California county have been so designated for the enclosed regulations on hospital reimbursement. We would therefore request that you post these regulations and the accompanying cover memo in your main county welfare office for a period of sixty days.

If you have any questions regarding this letter or the enclosed materials, please contact your Medi-Cal field representative.

Sincerely,

Original signed by

Elizabeth H. Lyman,
Deputy Director
Health Care Policy and Standards Division

Enclosure

cc: Medi-Cal Liaisons
Medi-Cal Field Representatives

Expiration Date: July 1, 1980

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STATE DEPARTMENT OF HEALTH SERVICES
PUBLIC HEARING ON REGULATIONS

On April 15, 1980, commencing at 10:00 a.m., the State Department of Health Services will hold a public hearing in the Auditorium at 714 P Street, Sacramento, California for the following agenda item:

Inpatient Hospital Reimbursement (R-6-80)	John Chambers (916) 445-8128	Title 22, Division 3 Repeal Sections 51508, 51508.1 through 51508.9. Proposed Regulation Section 51536.

The purpose of the hearing is to gather oral and/or written testimony from the public regarding the regulation changes under consideration. Attached you will find copies of recently published newspaper notices announcing the hearing and summarizing the regulation changes or containing the actual regulations. Also attached are copies of the actual regulation texts arranged in the order in which they will be considered at the hearing. Additions to the existing regulations are indicated by underscoring and deletions have been ~~stricken out~~.

The hearing will be chaired by a hearing officer delegated by the Director of Health Services to conduct the hearing in her behalf. Persons attending the hearing will be requested to complete a registration card at the door. Those persons wishing to present oral testimony will be requested to indicate on the card those agenda items to be addressed in their testimony.

Speakers will be called by the hearing officer as the appropriate agenda items are presented, and everyone wishing to speak will be given the opportunity to do so. All testimony will be recorded by a certified shorthand reporter, and speakers will be asked to approach the microphone at the front of the hearing room and state for the record their name and the organization they represent, if any, prior to presentation of their testimony.

Although in most instances the hearing record will be closed at 5:00 p.m. on the day of the hearing, the record on individual agenda items may be held open for extended periods, at the discretion of the hearing officer, it it becomes evident that relevant written public testimony may be gathered by doing so.

Persons unable to attend the hearing or wishing to present testimony during a hearing extension period may submit written statements to:

State Department of Health Services
Office of Regulations
714 P Street, Room 840
Sacramento, CA 95814

All testimony will be reviewed by the Department of Health Services prior to decision regarding final adoption of the regulation changes.

Any questions regarding the hearing may be addressed to the Department at the above address or by phoning (916) 322-4990.

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 322-4990

NOTICE OF PROPOSED CHANGES IN THE REGULATIONS OF THE STATE DEPARTMENT OF HEALTH SERVICES

Notice is hereby given that the State Department of Health Services, pursuant to the authority vested by Sections 14100, 14105 and 14106(a) of the Welfare and Institutions Code, and to implement, interpret, or make specific Sections 14105 and 14106(a) of the Welfare and Institutions Code, proposes to repeal and adopt regulations in Title 22, Division 3 of the California Administrative Code summarized as follows:

(1) Repeals Sections 51508 and 51508.1 through 51508.9, to delete current provisions on determining the cost of inpatient hospital services and on appealing the determination. Proposed Section 51536 incorporates new provisions on reimbursable costs and appeal procedures.

(2) Adopts Section 51536 to provide a new system for inpatient hospital reimbursement based upon the lesser of each hospital's customary charges, Medicare allowable cost or all-inclusive rate per discharge. The proposed regulation also provides for interim payment rates, final payment rates and an appeal procedure. This change is necessary in order to add provisions that conform to the proposed State Plan currently being reviewed by the United States Department of Health and Human Services.

Notice is also given that any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held in the Auditorium at 714 P Street, Sacramento, California, at 10:00 a.m. on the 15th day of April, 1980. The State Department of Health Services, upon its own motion or at the instance of any interested person, may thereafter adopt the above proposals substantially as above set forth without further notice.

The estimated fiscal impact upon Medi-Cal of the proposed regulation is a savings in Fiscal Year 1980-81 of $9,141,000 ($6,433,500 General Fund) (Full year, lagged). In Fiscal Year 1981-82, the savings is estimated to be $34,172,300 ($24,050,600 General Fund).

There are no costs or savings to local governments.

Inquiries or comments regarding these regulation changes may be addressed to Ron C. Wetherall, Chief, Office of Regulations, at (916) 322-4990.

The State Department of Health Services has determined that, pursuant to Section 2231 of the Revenue and Taxation Code, no increased costs or new costs to local governments will result from these regulation changes. Such determination will be made a formal part of the public hearing at the time and place described above.

A copy of the regulation summarized above may be obtained by writing to the Office of Regulations, State Department of Health Services, 714 P Street, Room 840, Sacramento, California 95814, or at the time and place of hearing.

STATE DEPARTMENT OF HEALTH SERVICES

R-6-80
5365

Richard H. Koppes for

Dated: 2/19/80

Original signed by

Richard H. Koppes, for
Beverlee A. Myers, Director

51508. Hospital Inpatient Services Reimbursement.

(a) Final settlement for acute care services furnished to Medi-Cal program beneficiaries by hospitals shall not exceed the lesser of the reasonable cost of such services or the customary charges therefor to the general public.

(1) Reasonable cost shall mean:

(A) For services rendered on and after July 1, 1975 through June 30, 1976, an amount not more than the average total cost per Medi-Cal patient day of service for the immediate 12 months preceding July 1, 1975, plus ten percent of said average cost. Average cost per Medi-Cal patient day of service shall be determined from the hospital's cost statement for the last full cost reporting period ending prior to July 1, 1975, and adjusted for actual costs incurred after such reporting period and prior to July 1, 1975.

(B) For services rendered on and after July 1, 1976 through October 14, 1976, an amount not to exceed the amount determined to be reasonable cost for the period July 1, 1975 through June 30, 1976 plus seven percent of said cost.

(C) For services rendered on and after October 15, 1976 through June 30, 1977, an amount not to exceed the amount determined to be reasonable cost for the period July 1, 1975 through June 30, 1976, plus seven percent of said cost.

(D) For services rendered on and after July 1, 1977 through September 30, 1977, an amount not to exceed the amount determined to be reasonable cost for the period July 1, 1976 through June 30, 1977, plus seven percent of said cost.

(E) For services rendered on and after October 1, 1977 through June 30, 1978, an amount not to exceed the amount determined to be reasonable cost for the period July 1, 1976 through June 30, 1977, plus seven percent of said cost.

(F) For services rendered on and after July 1, 1978 through February 28, 1979, an amount not to exceed the amount determined to be reasonable cost for the period July 1, 1977 through June 30, 1978 plus seven and one-half percent of said cost.

(G) For services rendered on and after March 1, 1979 through June 30, 1979, an amount not to exceed the amount determined to be reasonable cost for the period July 1, 1977 through June 30, 1978 plus seven and one-half percent of said cost.

(H) For services rendered on and after July 1, 1979 through August 31, 1979, an amount not to exceed the amount determined to be reasonable cost for the period July 1, 1978 through June 30, 1979 plus seven and one-half percent of said cost.

(I) For services rendered on and after September 1, 1979 through June 30, 1980, an amount not to exceed the amount determined to be reasonable cost for the period July 1, 1978 through June 30, 1979 plus seven and one-half percent of said cost.

(2) The Department shall use the "Health Insurance Regulations Manual" (HIRM-1) as issued and amended by the U.S. Department of Health, Education and Welfare for the administration of Title XVIII of the Social Security Act as amended; said manual shall be used by the Department as a guide for determining reasonable costs.

(3) Interim payments to hospitals shall be determined by the use, and adjustment to current status, of previous year cost information. For services rendered on and after July 1, 1979, interim payments shall not exceed the level of interim payments for the previous month by more than sixty hundredths of one percent.

(b) Payment for skilled nursing facility services shall be made in accordance with Section 51511.

(c) Payment for intermediate care facility services shall be made in accordance with Section 51510.

(d) Hospitals which are unable to submit a certified cost statement due to the lack of a year of operating experience shall be paid on an interim basis according to a certified statement of the current bill charges to patients.

NOTE: Authority cited: Sections 14105 and 14106, Welfare and Institutions Code. Reference: Sections 14105 and 14106, Welfare and Institutions Code.

HISTORY:

1. Amendment filed 9-1-77; effective thirtieth day thereafter (Register 77, No. 36). For prior history, see Register 76, No. 38.
2. Amendment of subsections (a)(1) and (a)(3) filed 2-5-79; effective thirtieth day thereafter (Register 79, No. 6).
3. Amendment of subsections (a)(1) and (a)(3) filed 8-1-79; effective thirtieth day thereafter (Register 79, No. 31).

Repeal

51508.1. Extraordinary Administrative Adjustments.

Upon the conclusion of any final audit or examination by or on behalf of the Department of Benefit Payments, any hospital meeting the criteria set forth in Section 51508.5 may apply for an extraordinary administrative adjustment of the reasonable cost for hospital inpatient services which was determined in accordance with subdivision (a)(1) of Section 51508. Such application shall be submitted in accordance with the procedures set forth in Sections 51508.3 through 51508.7.

NOTE: Authority cited: Sections 14100, 14105 and 14106, Welfare and Institutions Code. Reference: Sections 14100, 14105 and 14106, Welfare and Institutions Code.

HISTORY:

1. New section filed 6-2-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).

51508.2. Definitions.

(a) The following definitions are applicable to Sections 51508.1 through 51508.7.

(1) Applicant means a hospital which has filed an application for extraordinary administrative adjustment pursuant to the provisions of Section 51508.3.

(2) Component costs means the various categories of hospital operating costs, including salaries and wages, administrative operating expenses, food, drugs, and medical equipment and supplies, selected by the Department of Health for the purpose of estimating future cost increases.

(3) Geographic service area means the area included within a 25-mile radius of the applicant.

(4) Reasonable cost means reasonable cost as defined by subdivision (a) of Section 51508.

(5) Year in question means the year, or partial year, to which the notice of final settlement by the Department of Benefit Payments relates and for which the applicant seeks extraordinary administrative adjustment.

(6) Base period means the twelve month period immediately preceding the year in question.

(7) Mailing means the date postmarked on the envelope if postage was prepaid and the envelope was properly addressed.

NOTE: Authority cited: Sections 14100, 14105 and 14106, Welfare and Institutions Code. Reference: Sections 14100, 14105 and 14106, Welfare and Institutions Code.

HISTORY:

1. New section filed 6-2-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).

51508.3. Application.

(a) Within sixty calendar days of the mailing of a notice of final settlement by the Department of Benefit Payments, a hospital meeting each and every criterion set forth in Section 51508.5 may apply to the Department of Health for extraordinary administrative adjustment of the reasonable cost applicable to the hospital for the year in question. The application shall be in writing and shall contain at least the following information:

(1) The name and address of the applicant.

(2) The applicant's actual overall percentage increase, when compared to the base period, in the average total cost per patient day of inpatient hospital services for the year in question.

(3) The applicant's actual percentage increase, when compared to the base period, in total component costs and in each element of component costs for the year in question.

(4) The average daily occupancy rate based upon the applicant's licensed bed capacity for the year in question.

(5) A clear, concise statement of the grounds for the application for special administrative adjustment.

(6) A statement of fact, including supporting documentation, demonstrating that each criterion set forth in Section 51508.5 is fully satisfied.

(7) The amount of and justification for the adjustment requested.

(8) Such books, records, information and documentation as may be required to support the application.

NOTE: Authority cited: Sections 14100, 14105 and 14106, Welfare and Institutions Code. Reference: Sections 14100, 14105 and 14106, Welfare and Institutions Code.

HISTORY:

1. New section filed 6-2-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).

51508.4. Review of Application.

Upon receipt of an application meeting the standards of Section 51508.3, the Department of Health shall review and consider the application.

NOTE: Authority cited: Sections 14100, 14105 and 14106, Welfare and Institutions Code. Reference: Sections 14100, 14105 and 14106, Welfare and Institutions Code.

HISTORY:

1. New section filed 6-2-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).

51508.5. Criteria for Review.

(a) An application for extraordinary administrative adjustment may be granted in whole or in part only if each of the following criteria are met:

(1) The applicant's actual average total cost per patient day of hospital inpatient services for the year in question exceeds reimbursement criteria as set forth in subdivision (a) (1) of Section 51508.

(2) The applicant's actual percentage increase in one or more categories of component costs for hospital inpatient services or the overall average cost per inpatient day for the fiscal year in question, when compared to the base period, exceeds the following limitations:

(A) For services rendered during July 1, 1975, through June 30, 1976:

1. Salary and wages	10%
2. Administrative operating expense	24%
3. Food	21%
4. Drugs	26%
5. Medical equipment and supplies	17%
6. Overall average cost per inpatient day	11%

(B) For services rendered during July 1, 1976, through June 30, 1977:

1. Salary and wages	8.8%
2. Administrative operating expenses	14.0%
3. Food	13.0%
4. Drugs	17.0%
5. Medical equipment and supplies	11.0%
6. Overall average cost per inpatient day	8.0%

(C) For services rendered during July 1, 1977 through June 30, 1978:

1. Salary and wages	8.2%
2. Administrative operating expenses	13.0%
3. Food	20.0%
4. Drugs	15.0%
5. Medical equipment and supplies	12.0%
6. Overall average cost per inpatient day	8.0%

(D) For services rendered during July 1, 1978 through June 30, 1979:

1. Salaries and Wages	8.9%
2. Administrative Operating Expenses	13.0%
3. Food	25.0%
4. Drugs	16.0%
5. Medical Equipment and Supplies	13.0%
6. Overall average cost per inpatient day	8.5%

(E) For services rendered during July 1, 1979 through June 30, 1980:

1. Salaries and Wages	8.0%
2. Administrative Operating Expenses	16.0%
3. Food	23.0%
4. Drugs	18.0%
5. Medical Equipment and Supplies	13.0%
6. Overall average cost per inpatient day	8.5%

(3) The applicant had an average daily occupancy rate for licensed beds during the year in question, equal to or greater than 70%. This criterion may be waived if it is determined that a hospital's continued participation in the Medi-Cal program is necessary to assure an adequate number of available beds within the hospital's geographic service area.

(4) The applicant meets at least one extraordinary criterion such as, but not limited to, the following:

A. The applicant has undertaken a substantial new and necessary service during the year in question which has generated additional operating costs. The applicant shall demonstrate that the new service does not duplicate existing services within its geographic service area or that, if such services presently exist within such geographic service area, other facilities rendering the same or similar services are operating at full capacity with respect to such services. The applicant shall further demonstrate that the new service is necessary to provide adequate care and services to the general public served by the applicant. This demonstration shall be based upon population characteristics, disease incidence, projected utilization, and inaccessibility of similar services.

B. The applicant has changed its case mix. Such change in case mix shall be done in cooperation and conjunction with other hospitals within the applicant's geographic service area. Any increase in caseloads shall be documented. Such documentation shall also demonstrate a commensurate reduction in caseloads in the other hospitals.

NOTE: Authority cited: Sections 14100, 14105 and 14106, Welfare and Institutions Code. Reference: Sections 14100, 14105 and 14106, Welfare and Institutions Code.

HISTORY:

1. New section filed 6-2-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).
2. Amendment of subsection (a)(2) filed 5-20-77; effective thirtieth day thereafter (Register 77, No. 21).
3. New subsection (a)(2)(C) filed 2-8-78; effective thirtieth day thereafter (Register 78, No. 6).
4. New subsection (a)(2)(D) filed 2-5-79; effective thirtieth day thereafter (Register 79, No. 6).
5. New subsection (a)(2)(E) filed 8-1-79; effective thirtieth day thereafter (Register 79, No. 31).

51508.6. Recommendation.

Within ninety days of receipt of a complete application, the Department shall review the application in light of the criteria set forth in Section 51508.5 above, and shall submit to the Director of the Department of Health a recommended decision on the application for extraordinary administrative adjustment, together with the application and all supporting documentation. The recommended decision shall be in writing and shall contain findings of fact. The recommended decision shall state whether extraordinary administrative adjustment should be granted and, if so, in what amount.

NOTE: Authority cited: Sections 14100, 14105 and 14106, Welfare and Institutions Code. Reference: Sections 14100, 14105 and 14106, Welfare and Institutions Code.

HISTORY:

1. New section filed 6-2-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).

51508.7. Action by the Director.

(a) Within twenty-one days of receipt of the recommended decision, the Director of the Department of Health or his designee shall take one of the following actions:

(1) Adopt the recommended decision as his own.

(2) Reject the recommended decision and prepare his own decision based upon the application and supporting documentation.

(3) Return the recommended decision for further consideration.

(b) The applicant shall be notified of the Director's decision by mail.

NOTE: Authority cited: Sections 14100, 14105 and 14106, Welfare and Institutions Code. Reference: Sections 14100, 14105 and 14106, Welfare and Institutions Code.

HISTORY:

1. New section filed 6-2-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).

51508.8. Conditional Administrative Adjustments.

Upon the conclusion of any tentative settlement by the Department of Benefit Payments, any hospital meeting the criteria set forth in Section 51508.5 may apply to the Department of Health within 60 days for a conditional administrative adjustment of reasonable cost for hospital inpatient services which was determined in accordance with subdivision (a) (1) of Section 51508. Such application shall be submitted in accordance with the procedures set forth in Section 51508.3, subdivisions (a) (1) through (a) (8). Department approval or disapproval of a conditional administrative adjustment shall neither mitigate for nor against the hospital or the Department in the subsequent decision concerning the extraordinary administrative adjustment of the final settlement.

NOTE: Authority cited: Sections 14100, 14105 and 14106, Welfare and Institutions Code. Reference: Sections 14100, 14105 and 14106, Welfare and Institutions Code.

HISTORY:

1. New section filed 6-2-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).

51508.9. Medi-Cal Hospital Payment Rate Exception.

Any hospital with a high Medi-Cal occupancy rate may apply to the Department for a Medi-Cal exception to the determination of reasonable cost for services rendered from July 1, 1976 through June 30, 1977. Exception shall be allowed only if a hospital's average Medi-Cal inpatient occupancy rate, based upon licensed bed size, equals or exceeds nine and one-half percent during any single period of twelve consecutive months between July 1, 1975 and June 30, 1977. The exception shall not exceed the amount determined to be reasonable cost for the period of July 1, 1975 through June 30, 1976, plus ten percent of said cost. Notwithstanding Section 51508(a) (3), interim payments may be adjusted to reflect this Medi-Cal exception.

NOTE: Authority cited: Sections 14105, 14106 and 14161, Welfare and Institutions Code. Reference: Sections 14105, 14106 and 14161, Welfare and Institutions Code.

HISTORY:

1. New section filed 5-20-77, effective thirtieth day thereafter (Register 77, No. 21).

515 36. Hospital Inpatient Services Reimbursement.

(a) Reimbursement for hospital inpatient services provided to Medi-Cal program beneficiaries shall be the lesser of the following for each hospital:

(1) Customary charges.

(2) Allowable costs determined in accordance with applicable Medicare standards and principles of reimbursement.

(3) All-inclusive rate per discharge.

(b) The following definitions are applicable to this Section:

(1) Base year means the hospital accounting year immediately preceding the year for which final settlement is being concluded.

(2) Final settlement year means the hospital accounting year for which final settlement is being concluded.

(3) Interim-rate period means the 12-month period beginning July 1 of each year.

(4) Allowable cost means the hospital's allowable Medi-Cal cost permitted by applicable Medicare standards and principles of reimbursement (HIM-15).

(5) Reimbursable cost means the lesser of each hospital's customary charges, allowable cost, or all-inclusive rate per discharge multiplied by the number of Medi-Cal discharges.

(6) Rate per discharge means the hospital specific, all-inclusive rate per Medi-Cal discharge which, when multiplied by the number of Medi-Cal discharges, including deaths but excluding newborns, in the hospital's accounting year, determines the total dollar limit on reimbursable cost for that accounting year.

(7) Interim rate means the hospital specific, all-inclusive rate payable per Medi-Cal patient day, excluding newborns, for all covered inpatient services provided by the hospital during the interim-rate period.

(8) Pass-through categories means those hospital cost categories which, for purposes of final settlement, are not subject to the hospital cost index. Pass-through categories are limited to:

(A) Depreciation.

(B) Rents and leases.

(C) Interest.

(D) Property taxes and license fees.

(E) Medicare allowable return on equity capital for proprietary facilities.

(9) Service intensity means the necessary changes in the character of the services provided to each patient, including changes in applicable technology, qualitative changes in personnel, quantitative changes in personnel, qualitative changes in supplies, drugs, and other materials, and quantitative changes in supplies, drugs, and other materials. Service intensity does not include changes in the types of patients and illnesses treated.

(c) The unit of payment for inpatient hospital services shall be as follows:

(1) An all-inclusive rate per discharge shall be retrospectively established for each hospital's final settlement. The rate per discharge shall:

(A) Apply to all covered services provided by the hospital during its final settlement year.

(B) Be updated annually to reflect reimbursable changes in factor input prices, service intensity, patient volume, and other items allowed through the appeals process.

(C) Incorporate, as necessary, estimated allowable costs incurred prior to the effective date of this regulation.

(2) An all-inclusive rate per patient day shall be prospectively established for each hospital's interim reimbursement. The interim rate shall:

(A) Apply to all covered services provided by the hospital during the interim-rate period.

(B) Approximate the hospital's reimbursable cost of service during the interim-rate period.

(d) A hospital cost index shall be established for each hospital. This index shall consist of an input index and an allowance for changes in service intensity.

(1) Estimates of the hospital cost index shall be used to calculate each hospital's interim rate prior to the beginning of each interim-rate period. The interim rate shall be calculated by applying the estimated hospital cost index to the hospital's reimbursable cost per patient day for its most recently concluded accounting year.

(2) The hospital cost index shall be recalculated to account for actual changes in the input price index after the close of each hospital's accounting year. The recalculated hospital cost index shall be applied to the hospital's rate per discharge for the base year to determine its rate per discharge for the final settlement year.

(e) An input price index shall be established to compute the reimbursable change in the prices of goods and services purchased by hospitals. The input price index shall consist of a market basket classification of goods and services purchased by hospitals, a corresponding set of market basket weights derived from each hospital's own mix of purchased goods and services, and a related series of price indicators.

(1) The input price index shall be calculated for each hospital by:

(A) Computing weights which represent the proportion of cost in each market basket category to total cost in the hospital.

(B) Multiplying the weight in each category by the percentage change in the related price indicator.

(C) Summing the results.

(2) The market basket categories and price indicators to be used in developing each hospital's input price index are shown in the following table. Initial estimates of changes in the price indicators shall be

derived from nationally accepted econometric forecasts, including, but not limited to, estimates made by the United States Department of Health and Human Services for use with the National Hospital Input Price Index. These forecasts shall be adjusted if necessary to reflect estimated differences specific to California.

PRELINED DRAFT PAPER INDICATES AND IS TO BE USED ONLY FOR ALL NEW REGULATORY LANGUAGE.

DRAFT — FOR DISCUSSION ONLY
Date FEB 8 1980

51536 - 7

MARKET BASKET CLASSIFICATION

MARKET BASKET CATEGORIES	PRICE INDICATORS	
	VARIABLE	SOURCE
(1) Payroll Expenses:		
(a) Physicians' Salaries, Wages, Fees and Benefits	Physicians' service component	Consumer Price Index, All Urban Consumers
(b) Other Employees' Salaries and Wages	Average hourly earnings: service industry or non-supervisory hospital workers	U. S. Department of Labor Bureau of Labor Statistics
(c) Other Employees' Benefits	Average supplements to wages and salaries per nonagricultural employee	Supplements: U. S. Department of Commerce, Bureau of Economic Analysis Number of Employees: U. S. Department of Labor, Bureau of Labor Statistics
(2) Professional Fees, other than physicians	Hourly earnings, production or nonsupervisory, private nonagricultural employees	U. S. Department of Labor, Bureau of Labor Statistics
(3) Depreciation:		
(a) Building and Fixed Equipment	Implicit price deflator, investment, private, nonresidential structures	U. S. Department of Commerce, Bureau of Economic Analysis
(b) Movable Equipment	Implicit price deflator, investment, private, nonresidential producers' durable equipment	U. S. Department of Commerce, Bureau of Economic Analysis

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(4)	Interest:		
	(a) Working Capital	Prime rate on short-term loans to large business corporations	Federal Reserve System, Banking Section, Division of Research and Statistics
	(b) Capital Debt	Yield on domestic municipal bonds	U. S. Department of Commerce, Bureau of Economic Analysis
(5)	Hospital Malpractice Insurance	Estimated malpractice insurance premiums	Major insurance underwriters providing coverage to California hospitals
(6)	Food	Average of processed foods and feeds component of PPI, and food and beverages component of CPI	Producer Price Index Consumer Price Index, All Urban Consumers
(7)	Utilities:		
	(a) Electricity	Implicit price deflator, consumption of electricity	U. S. Department of Commerce, Bureau of Economic Analysis
	(b) Natural Gas	Implicit price deflator, consumption of natural gas	U. S. Department of Commerce, Bureau of Economic Analysis
	(c) Water and Sewerage	Water and sewerage maintenance component	Consumer Price Index, All Urban Consumers
(8)	License Fees and Taxes, other than income	Property tax revenues, adjusted for new building starts	California State Department of Finance
(9)	Other Costs:		
	(a) Drugs	Pharmaceuticals and ethicals component	Producer Price Index
	(b) Chemicals	Chemicals and allied products component	Producer Price Index
	(c) Medical Instruments and Appliances	Special industry machinery and equipment component	Producer Price Index

(d) Rubber and Plastics	Rubber and plastics component	Producer Price Index
(e) Travel	Transportation component	Consumer Price Index, All Urban Consumers
(f) Apparel and Textiles	Textile products and apparel component	Producer Price Index
(g) Business Services	Services component	Consumer Price Index, All Urban Consumers
(h) All Other	All items	Consumer Price Index, All Urban Consumers

(3) Weights corresponding to market basket categories shall be derived and annually updated for each hospital. These weights shall be computed using the latest available information from each hospital's Medi-Cal cost report, financial disclosure report, or other direct report of expenses. If information from these sources is not sufficient to establish a hospital specific weight for a particular market basket category, the Department of Health Services shall assign a representative weight based on information from the National Hospital Input Price Index published by the Department of Health and Human Services, or other available sources.

(4) The input price index shall be recalculated after the close of each hospital's accounting year, to account for actual changes in the hospital specific wage rates and market basket weights for nonsupervisory personnel, the price indicators and market basket weights for other nonpass-through categories, and the allowable cost for pass-through categories.

(f) An annual service intensity allowance of one percent for reimbursable increase in service intensity shall be added to each hospital's input price index. This allowance shall be in addition to reimbursement for service intensity increases flowing from pass-through categories and approved appeals.

(g) A volume adjustment shall be made to the hospital's rate per discharge for the final settlement year if the number of total hospital discharges in the hospital's final settlement year differs from the number of discharges in its base year.

(1) The volume adjustment shall be calculated using the following formula, which adjusts the rate per discharge for estimated changes in average costs resulting from changes in volume.

VOLUME ADJUSTMENT FORMULA

$$ACR = HCI - \frac{DIS_B + VC\ (DIS_F - DIS_B)}{DIS_F}$$

Where:

ACR = Allowable change in the rate per discharge after volume adjustment, expressed as a proportion of the base year rate per discharge.

HCI = Hospital Cost Index before any volume adjustments, expressed as a proportion of the base year rate.

DIS_B = Total hospital discharges in the base year.

VC = Variable cost as a proportion of total cost.

DIS_F = Total hospital discharges in the final settlement year.

(2) Each hospital's total cost shall be divided into the fixed and variable components shown in the following table. Data from the hospital's financial disclosure report or other direct report of expenses shall be used to estimate the percentage of a hospital's cost which varies with volume. A fixed to variable cost ratio of 50:50 shall be used when sufficient data from the hospital is not available.

CLASSIFICATION OF FIXED AND VARIABLE COSTS

FIXED COST	VARIABLE COSTS
SALARIES AND WAGES	SALARIES AND WAGES
Management and supervision	Registered nurses
Technician and specialist	Licensed vocational nurses
Clerical and other administrative	Aides and orderlies
Physicians	Environmental and food services
Nonphysician medical practitioners	Other salaries and wages
EMPLOYEE BENEFITS - Distributed proportionately according to salaries and wages	EMPLOYEE BENEFITS - Distributed proportionately according to salaries and wages
FICA	FICA
Unemployment insurance	Unemployment insurance
Vacation, holiday, and sick leave	Vacation, holiday, and sick leave
Group insurance	Group insurance
Pension and retirement	Pension and retirement
Workman's compensation	Workman's compensation
Other employee benefits	Other employee benefits
OTHER DIRECT EXPENSES	PROFESSIONAL FEES
Depreciation and amortization	Medical
Utilities	Consulting and management
Insurance	Legal
Licenses and taxes (other than income)	Audit
Other direct expenses	Other professional fees
	SUPPLIES
	Food
	Surgical supplies
	Pharmaceuticals
	Medical care materials
	Minor equipment
	Nonmedical supplies
	PURCHASED SERVICES
	Medical
	Repairs and maintenance
	Management services
	Other purchased services

(h) A hospital may appeal all-inclusive reimbursement rates established for that hospital if the hospital's allowable cost exceeds or is expected to exceed reimbursement based on those rates.

(1) The following items are not subject to appeal under the procedures in Section 51536 (h) (3):

(A) The use of Medicare standards and principles of reimbursement.

(B) The method for determining the input price index.

(C) The use of all-inclusive reimbursement rates.

(D) The use of a volume adjustment formula.

(E) The interim-rate period.

(2) The following items may be appealed under the procedures in Section 51536 (h) (3):

(A) The addition of new and necessary services.

(B) Changes in case mix.

(C) Inappropriate calculation of fixed and variable costs.

(D) The use of incorrect data or an error in calculations.

(E) Other items affecting hospital costs.

(3) The procedures for appeal of an all-inclusive rate shall be as follows:

(A) An appeal of the all-inclusive rate per patient day shall be submitted within one year after notification of that rate. An appeal of the all-inclusive rate per discharge shall be submitted within 60 days after notification of that rate.

(B) The appeal shall be submitted in writing to the Department and shall specifically and clearly identify the issue and the total dollar amount involved. The hospital shall demonstrate at least one of the following:

1. Costs for which additional reimbursement is being requested are necessary, proper, and consistent with efficient and economical delivery of covered patient care services.

2. Incorrect data were used.

3. An error was made in the rate calculation.

(C) The hospital shall be notified of the Department's decision in writing within 90 days of receipt of the hospital's written appeal, or within 90 days of receipt of any additional documentation or clarification which may be required, whichever is later.

(D) The Department may require the hospital to submit to a comprehensive operational review as a condition of appeal. The review shall be made at the discretion of the Department and may be performed by either the Department or its designee. The findings from any such review may be used by the Department to recalculate reimbursable costs for the hospital.

(i) New hospitals shall be exempt from the provisions of this section relating to the use of all-inclusive rates per discharge. A new hospital is one that has operated under present and previous ownership for less than three years. A new hospital shall be:

(1) Reimbursed in accordance with applicable Medicare standards and principles of reimbursement.

(2) Paid an all-inclusive rate per patient day for interim reimbursement. This rate shall be subject to review by the Department at least once every six months.

(j) Each hospital shall be notified of the:

(1) Interim rate prior to the effective date of the interim rate.

(2) Rate per discharge at the time of tentative and final settlement.

(k) A change in base year reimbursable costs shall result in a redetermination of all-inclusive rates per discharge.

(l) Payment for skilled nursing facility services shall be made in accordance with Section 51511.

(m) Payment for intermediate care facility services shall be made in accordance with Section 51510.